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ABSTRACT

After discussing the rhetorical nature of physician/patient interactions, this paper describes and analyzes six medical interviews to illustrate the evolution of interpersonal and role relationships between physicians and patients, the sorts of information that are shared, and the way problems are resolved. The interviews that are described consist of two from family practice, two from internal medicine, and two from pediatrics. They vary in duration from 15 minutes to an hour: the sample of physicians is weighted toward white, American, male residents: and the patient population is white, evenly divided between sexes, and representative of a range of ages and socioeconomic levels. Among the findings discussed are that the physicians took primary responsibility for asking questions and for initiating topics: that they tended to explain, prescribe, demonstrate, remind, and repeat; that they used various approaches to attempt to gain patient cooperation: and that they were acknowledged as the experts in the interviews, an assumption that helped them to order and regulate the interviews, but one that led to a passive role by patients. (GT)

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A RHETORICAL APPROACH TO UNDERSTANDING THE MEDICAL INTERVIEW

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Introduction

The form and quality of communication between physicians and patients is a subject gaining increasing attention from a number of different groups. Health educators are urging patients to voice their questions and concerns to physicians as a step toward exercising informed choices in their medical care.[1] Training in interpersonal communication has become widely, if not deeply, entrenched in medical school curricula throughout the country.[2] This trend in medical education has been prompted by primary care disciplines, most notably family practice, which perceive diagnostic and therapeutic value in talking with patients. Practicing physicians demonstrate varying degrees of concern in the communication process due to a number of pragmatic factors ranging from malpractice suits to patient adherence with doctor's orders.[3]

While such attention from all major parties involved in this form of discourse suggests a desire for greater effectiveness and satisfaction, a first step for the communication scholar is to understand physician-patient interaction as it is practiced currently. A primary assumption in this study has been that a rhetorical frame of reference is one valid approach toward gaining such understanding. There is at least one distinctly persuasive issue associated with the physician-patient dialogue. The matter of whether patients indicate willingness and ability to follow through on a plan of treatment -- most often referred to as "patient compliance" -- is one of which most medical practitioners are very aware and concerned. The physician's

capacity to gain the patient's cooperation in this respect is crucial to therapeutic effectiveness.

A more generalized rhetorical concern is the ways in which patients and physicians collaborate in order to shape the particular discursive form in which they participate jointly. As will be demonstrated in the following analysis, the compliance issue is actually subsumed within this larger theme.

Rhetorical Quality in the Medical Interview

To further substantiate a rationale for proceeding rhetorically with an investigation of medical communication, it is necessary to examine in detail the nature of the discourse under discussion. Physician-patient interaction is frequently characterized as interviewing in that it usually assumes a question-answer format. As with other interview situations, the interchange is not random, but purposeful, its goals being information-gathering and problem-solving. Intentionality has often been used as a characteristic that distinguishes the rhetorical from other communication.[4] Thus, goal orientation is one important reason for using a rhetorical approach with the medical interview. Secondly, the development of each interview is a process that reflects the verbal pushing and pulling of the participants. What, when, and how things are discussed is a matter of continuous negotiation -- sometimes overt, often subtle. Because the transaction that evolves between interview participants is not composed of haphazard contributions, there are strategic choices being made. The exercise of strategy is the other important reason for viewing the medical interview as rhetorical.

It is essential to note at this point an a priori premise about the nature of rhetoric that will be operationalized in the remainder of this study. In approaching non-public discourse, including dyadic interviews, the rhetorical critic must be cognizant of both content and relationship aspects. That is to say, meta-communication, the ways in which a relationship evolves and is symbolically managed, is as persuasive an undertaking as the evolution and management of the substance of talk. In physician-patient interaction, this rhetorical aspect of communication often proves to be as salient a feature in health care as the information exchanged.

Thus far, the description of medical communication does not differ from other interview situations. However, there are specific attending conditions that distinguish this type of transaction from other information gathering interviews:

1) both participants possess essential and complementary forms of information;
2) societal role expectations often cast the physician as the more powerful and proactive, and the patient as less powerful and reactive;
3) the content of the discourse is often of a serious and worrisome nature, sometimes literally affecting life or death decision-making; and
4) time constraints for the physician are often pressing, contributing toward a striving for a tenuous balance between verbal facilitation and control during the interview.

Thus, the skeleton of a rhetorical situation has been delineated. The task which remains is to fill in the flesh and blood -- that is, content

and relationship -- details. Hopefully, the resultant depiction will lead to a fuller understanding of how such talk "works" and to what ends from a rhetorical vantage point.

Research Design

In order to address the task, a sample of six medical interviews were studied. They are similar insofar as all are physician-patient interviews in community, ambulatory, primary care settings; they were videotaped for the purpose of physician training. The three major primary care disciplines are represented: two from family practice, two from internal medicine, and two from pediatrics. The interviews vary in duration from fifteen minutes to an hour; they include both initial and continuing contacts. The sample of physicians is weighted toward white, American, male residents, while the patient population is white, evenly divided between sexes, and spans a range of ages and socioeconomic levels. (Specific details will be found in the case studies which follow.)

Three critical questions were posed for each of the six case studies, in an effort to assess the ways in which physicians and patients influenced the discourse and one another. These include:

1) How do interpersonal and role relationships evolve between the participants?
2) What sorts of information are shared?
3) In what ways are problems resolved?

Case Study Analysis

Family Practice I

This interview is the second encounter between physician and patient, following a recent visit by the patient to the emergency room, where she first was seen by this doctor. The patient is an obese female, approximately twenty years old, from a blue-collar socioeconomic background. The physician is a white, American male, approximately thirty years old, engaged in residency training. The interaction is relatively lengthy, taking close to an hour.

As the interview begins, the patient greets the doctor, sounding and looking very depressed. Although the physician was with her in the emergency room, he asks her to relate "what happened on Sunday," thus eliciting her perceptions of the problem and her decision to come to the emergency room. She tells of severe abdominal pains which have since continued, and he probes for greater specificity by asking her to describe the pain on a scale of one to ten. Thus, in the first few minutes, a pattern of verbal exchange emerges that will characterize much of the remainder of the session. The patient establishes herself as passive and indirect, choosing to communicate some important messages nonverbally. The physician assumes the task of initiating and eliciting information through the use of open-ended questions that encourage more active participation on the part of the patient. He also determines the degree of detail and direction through more close-ended follow-up questions.

Another form of influence by the resident is to assume control of topic changes. Thus, he quickly moves away from the acute problem to ones of a

more chronic nature. He makes reference to her weight problem, though she professes she does not know why her weight is up. He then asks about her family situation and she responds with an elaboration of her living situation with her father, brother, and baby son. While probing this subject, the doctor changes focus by emphasizing her feelings toward her divorced parents and siblings. He encourages her to label her affect in each relationship, which forces her to clarify her own feelings. They also talk about the communication networks among family members. In this portion of the interview, many family problems are brought to light.

When the physician poses the next open-ended question -- "What thoughts have been in your head lately" -- the patient exercises some control by re-pointing the interview toward the more concrete issue of her stomach pains. When she asks what is wrong, the resident admits that there are no physical or laboratory findings to support the existence of disease. Organizationally, this exchange prompts an interesting reaction. In the context of other problems discussed, the news that there is no apparent physiological cause for the patient's symptoms implies the roots of the trouble must be found elsewhere. After a brief silence, the patient asks, as if dreading the response, "Is it my nerves?" Taking advantage of the patient's insight, the doctor returns to the previous topics, suggesting that she join a hospital-sponsored weight control group. His approach to the family dynamics issue is less directive and again facilitates the patient's participation, this time in problem-solving. She answers by saying she would like to be out of the house more and then admits many fears about taking her infant outside.

At this point, the resident chooses to alleviate some of the tension provoked through this discussion, by doing a brief physical examination of her abdomen. Aside from the information gathering involved with that procedure, the physical exam also seems to work on a symbolic level, assuring the patient that her symptoms are real and that the doctor is concerned about them. During the exam, she is tender to the touch and he holds her hand during the more painful moments. Once attention has been given to the physical ailments, the time seems riper for a return to the more sensitive emotional problems. He again broaches the suggestion of her coming to the weight clinic and she promises to attend in convincing tones. The doctor then attempts to persuade her that her fears about taking her baby outside are irrational and should not keep her indoors so much of the time. In regard to this latter argument, the patient seems to remain doubtful; promise of compliance is less certain.

The interview ends as the patient is asked to return in two to three weeks. She replies, "You're the doctor," confirming her selection of a passive role. Her incipient feelings of dependence emerge as she admits her fear of not being able to reach the physician in case of a sudden pain.

In summary, the nature of the information shared in this interview is wholistic, in that psychological aspects of the patient's illness are correlated with the physical, an approach often associated with family practitioners. The heavier emphasis on the psychological in this case is both a medical and rhetorical choice on the part of the physician; given the information elicited concerning the patient's psychosocial realm, he might have drawn the interview to a quicker close and referred her to a psychotherapist.

Instead, he decides to build on their relationship and try to manage her medical problems with an appeal for behavioral changes.

Accordingly, he proceeds to stress factors other than the immediate stomach pain. While control of topics is a direct form of influence, less obvious and more masterful is the resident's inductive leading of the patient to her own realization of emotional problems. The assymetry of the role relationship is immediately clear, not only in the patient's passive posturing and the physician's willingness to orchestrate the interview, but in smaller details such as modes of address: the resident is called "Dr.", the patient is known by her first name. It is no surprise that the patient expects solutions to be given to her by the doctor. Even so, he manages a subtle change in the role relationship. In part, this is achieved by warm support. The resident presents himself as accepting and nonjudgmental; he encourages long answers, is open to questions, and is not rushed to finish the interview; he talks through feelings, family problems, and empathizes with the patient's expression of stress. As has been stated, the physician encourages her participation through open-ended questions and even a suggestion for her own therapy. It is interesting that the patient seems more willing to comply with the doctor's order to attend the weight clinic than to follow through on her own idea to get out of the house, even with the physician's approval. It should be noted that both suggestions emphasize self-management. While joint problem-solving is not achieved in this interview, the physician appears to be leading toward that end.

Family Practice II

This situation illustrates a dilemma common to many primary care physic ans at some point. A woman in her mid-thirties, once again from a blue collar background, brings in her four year old son for treatment. The child, thus, is the patient, but the attending parent is an important source of information and a crucial agent in carrying out the therapy. The doctor, in this case, is a young, white, American, male resident who conducts an interview lasting approximately one half hour.

As the physician enters the examination room, he sits across from the boy on a stool which puts them at about the same height. After consulting the chart to recall the reason for the child's last visit and create a sense of continuity, he talks with the patient, establishing some rapport. The mother then tells the doctor she has brought the child for two reasons, to have his hearing tested and to discuss a problem with his toilet training. It becomes immediately apparent that the latter is the more important issue. The mother elaborates in great detail her previous attempts to train her child. The resident intervenes to ask for different sorts of detail than what she has volunteered. While the mother is intent on proving that she has done her best, the doctor focuses on such situational factors as the kind of toilet used. As if to further make her point, the mother turns to the child and asks him where he's "supposed to do pooh-pooh." When the boy says he doesn't know, her tone becomes shaming and accusing, as though her attempt to "show off" for the doctor has been foiled.

The resident takes the pressure off the child and the parent by once again focusing on the circumstances surrounding the problem, such as who cleans up, the child's personality, and the type of bowel movement. Then,

talking with the little patient, the doctor lifts him onto the examining table, first completing the ear exam before going on to a complete physical. Since it is necessary to perform a rectal exam, the physician is careful to calm the child and explain that it will be uncomfortable but will not hurt.

Having made sure that there are no organic causes for the problem, the doctor gives the mother a number of directives to alter her toilet training methods, including a change to a kiddie toilet and setting up a consistent time pattern. In a timely gesture to remind the adults of his part in the situation, the child interrupts by falling from the examination table and is invited by the resident to join them in a chair. This little drama, in effect, demonstrates the physician's subsequent and most adament piece of advice -- for the mother not to punish her son for "accidents" and to positively reinforce the good behaviors. The mother appears to accept these recommendations and promises to return in three months.

In this transaction, there is a subtle struggle for dominance between mother and doctor. The latter is unquestionably regarded as an authority figure. It is for that very reason that the mother wishes to argue her own "innocence" in light of the "crime" being committed. This motive seems as crucial to her as solving the problem itself. In order to not take responsibility for the toilet training problem, the mother must identify the issue in another way. Thus, either a physiological cause must be found or the child becomes the source of the trouble. Indeed, there are not physical findings and the mother does attempt to hold the child responsible for knowing better.

For his part, the physician must quickly assess the problem on the basis of data gathered from the patient, the mother, and the interaction between the two. Rather than delve further into the sensitive feelings of each, he chooses to emphasize more objective, factual aspects. By so doing, he avoids matters of approval or blame and stresses problem solving as the major and appropriate order of business. His accompanying role behaviors support this theme, as well. While he is understandably gentle with the child, his tone with the mother is neutral and businesslike. When he finds himself vying for control of the interview with the mother during the first half, only by repeatedly establishing his line of questioning is he able to direct the flow of the discourse. The non-personalized approach to problem-solving, the resident's defusion of the tension between mother and son, and his subsequent response to the child's interruption can all be regarded as an inductive argument to the mother that it is undesirable to blame the little boy for the problem. Once the physician has asserted his influence in this respect, the mother seems to offer no resistance to his directives at the end of the meeting, accepting his advice as authoritative.

Internal Medicine I

This visit to the doctor is one in a series between a physician and patient who have already established some norms and expectations in their communication. This patient is a middle-aged female from a middle-class background; the physician is also middle-aged, a white, American, male hospital attending and member of the faculty. The interview takes place in a somewhat formalized setting with the participants sitting kitty-cornered

around a desk, the doctor taking notes and adding to the chart; it lasts over thirty minutes.

As the interview begins, the physician asks the patient if she has brought her list. She replies that she has some questions to ask. The doctor does not respond directly to this remark, but goes to the chart to review the family history. He inquires how her daughters are getting along. She reports in detail that one is having marriage difficulties, while the other is having a problem with her contacts. The doctor makes a definite transition when he asks firmly, "Shall we deal with your list?" Without a moment's hesitation, she talks about shoulder and neck pain. He structures her open-ended response with probing questions about when it hurts and what she's done. As the interview proceeds, this pattern continues. The patient brings forth a bewildering array of complaints and observations, including a dissipation of depression, a throbbing in the head, stomach weight, hot flashes, bowel movements, gas, allergies, alcohol intake, medications, a nervous stomach, eye problems, leg aches, and pain during intercourse. The doctor works to extract specifics, move the discussion along, and evoke certain topics. She is the flow; he is the filter.

Rhetorical issues in this exchange are overt. The physician is continuously engaged in a regulatory function, of which the patient seems oblivious, as well as in a few ongoing persuasive campaigns for compliance. The list requested by the doctor at the start is apparently a device aimed at helping the patient to focus on immediate problems. He imposes some order on the discourse by introducing family history, review of organ systems, and the physical examination at certain points during the interview. Probing

questions are used to separate and highlight medically important data, while transition statements gently prod the patient on to other subjects and keep the discussion from bogging down in extraneous detail. At one point, he must admonish her to mention only ongoing problems and not bring up past history. In a few instances, the physician reminds the patient of self-management techniques that she is supposed to be practicing. For example, when she complains of a throbbing in her head, he asks if she has taken her pulse ("we talked about that"). She replies, "I don't take my pulse." Later, when she tells of pain during intercourse, he reminds her to use lubricating jelly, a subject that has also been discussed previously. The physician is careful to assure the patient that this procedure is "okay."

Despite the symbolic tension for control implicit in this transaction, both participants seem at ease with one another. The physician has elicited a great deal of information, while the patient is comfortable in discussing what worries her and to ask questions of a sensitive nature. A factor for the doctor to consider is that she appears highly suggestible, ready to supply symptomatic information on whatever topic he might mention. The tendency of the doctor to do so seems more problematic than helpful. It is clear that the compliance issues will not be resolved as a result of this visit, but the physician uses the opportunity to repeat his counsel and encourage changes. He brings the interview to a close by emphasizing a point the patient herself has made earlier; he states that she is getting along well and has shed her depression. Despite the numerous ailments the patient has claimed, she agrees with this summation. The doctor's authoritative conclusion is the most salient message to emerge.

Internal Medicine II

Like the previous internal medicine interview, this case could be classified as a maintenance-type visit in which the patient has no acute problem to report, but is attempting to cope with chronic difficulties. It is not clear how lengthy a relationship this elderly, heavy-set, lower middle class male has had with the young, white, male resident; however, there has been at least one other previous contact. The patient also is being seen by an older, more experienced attending physician at the same hospital. Though the interchange is short in duration, barely fifteen minutes, there is much of a rhetorical nature occurring.

At the start of the interview, the patient begins to review his medical history, mentioning a hodge-podge of details concerning a previous operation, a trip to the emergency room, and a bevy of names of previous doctors. The resident maneuvers to take over the direction of the transaction by refocusing on the current health of the patient with a series of very specific questions that move the interview along easily (although the patient manages to slip in an old gall bladder surgery). He elicits information about recent chest pain, as well as the patient's effort to lose weight. Following up on the latter theme, he asks about the patient's relationship with the nutritionist. The patient reports that he has received very positive feedback from her since he's lost four pounds; "she makes me feel like I'm a big hero." "You are! Four pounds is great," replies the physician approvingly.

Weight loss, then, is one major, chronic problem. The physician introduces a second one, diarrhea, checking to see if the patient has been

taking a prescribed medication. The patient confirms that the medication has worked to quiet his stomach. The doctor explains carefully that the prescription will have to be taken "all the time." This line of conversation motivates the patient to mention a duodenal ulcer he once had. The doctor gives no reinforcement to this comment and it is dropped.

Finally, the patient mentions that he has an appointment with the attending, previously set while the resident was away on vacation. He reports that the attending physician is angry with him since he felt he had done all he could and the patient still had not lost weight. The resident listens non-judgmentally and promises that both he and the attending will see the patient on his next visit. He also will set up an appointment for the patient with the nutritionist. Before the interview ends, the patient inserts a comment about a heart attack he has had. The resident performs a brief physical exam in order to listen to the patient's heart and chest.

Despite the brevity of the conversation, the pace is not hurried. The doctor gives the appearance of being relaxed, sitting back in his chair. The patient is informal, joking, and, obviously, has a tendency to dwell on past health care incidents. The physician must continually direct the flow of talk, taking the initiative to introduce and change topics, while gently cutting the patient off from time to time. Closed-ended questions become the most effective discursive technique for shaping the transaction. Even in this rather commonplace exchange, persuasive matters are at stake. The stomach medication is clearly a compliance issue. Not only does the doctor confirm the patient's willingness to follow orders, but works to change his expectations from temporary to the long term.

The more difficult compliance problem is weight loss. The physician positively reinforces the patient's progress. The importance of this seemingly simple response becomes emphasized when the patient brings to light the anger of the other physician. Thus, the nature of the relationship between patient and doctor becomes an influential factor in the resolution of a medical problem.

Pediatrics I

As in the earlier case study, this interview involves a parent, child, and physician. The purpose of the visit is a "well baby check." The patient in this case is a two month old male infant with a young, upper middle class mother in her mid-twenties. The doctor is a male, Indian resident in his late twenties. It becomes apparent very soon into the half hour interview that the mother is not very talkative, choosing not to volunteer information and to respond to questions as briefly as possible. The physician, thus, is faced with a difficult communication situation and adapts in a creative way.

When the participants enter the room, the doctor instructs the mother to place the baby on the examining table. He talks and plays with the child, establishing rapport. They then sit down, the mother holding her infant, in an informal, kitty-cornered arrangement. The doctor begins by asking generally how the mother is doing. A series of more specific questions follows concerning nursing habits, the father's involvement, bathing, taking the baby outside, mother-child verbal interaction, and sleeping patterns. After reviewing the content of their last visit, he asks the mother if there are any problems. Throughout this exchange, the mother responds in short, terse answers, focusing much of her attention on her son.

For his part, the resident attempts to include the baby, who is babbling and playful. As the conversation proceeds, he integrates his own observations of the baby (alertness, eye focus, strength) and instruction to the mother with his own questions.

As they move on to the physical examination, the resident remarks that the infant is gaining weight slightly more than the average amount. He elaborates that the child is in the seventy-fifth percentile, meaning that of one hundred babies, only twenty-five will be ahead of her son. Since height and weight are considered together, he is not obese. This explanation seems to please the mother and for the first time, she responds with enthusiasm. He then compliments the nursing she has been doing, checks to see if she will continue, and again supports her efforts. As he performs the physical, he addresses the infant by name, and is careful to tend to the comfort of the child, warming his stethoscope, and providing a sheet when the mother indicates that the baby is cold. He explains procedures to the mother as he performs them, as well as providing feedback as he reviews each organ system. As he examines the circumsized area, he demonstrates to her the correct method of cleaning. By this point, good, comfortable interaction has developed among the three. The resident further invites the mother's participation by phrasing questions in a way that requires elaboration: Why does she believe he can hear correctly? She replies with situational illustrations.

Once the physical exam is over, the physician spends time in accomplishing a number of tasks while concluding the interview. He summarizes that the baby is healthy in all respects, including height, weight, and motor skills; reiterates instructions he has given the mother in regard to bathing,

a new car seat, and filling out birth certificate materials. He explains vaccines that the baby will receive, along with possible reactions and a prescription for a remedy, as well as instructions for using the medication. She is again complimented on her care of her son, is asked for other questions, and encouraged to call if she has a concern. When asked to return in two months, her response is very positive, as are her assurances that she will follow through on his instructions.

The reasons inhibiting the mother's communication are not clear. She seems shy and very absorbed in her child. While her tone is not unfriendly, there is the possibility of mistrust of physicians; the baby was born at home without a doctor's assistance. The resident assumes the task of building a trusting relationship with both parent and child. Since the mother presents virtually no information about herself, rather choosing to identify herself as an extension of the infant, most of the doctor's rapport building efforts are directed at the baby. By showing a genuine concern and pleasure with the son, the physician indirectly works to win the trust of the mother. Open ended questions with a specific focus facilitate her contributions to information gathering. Positive observations on the development of the baby seem to be perceived as reflections of competent mothering, thus drawing out her gradual enthusiasm and participation in the interview.

As with the role of the physician in the other case studies, this doctor is viewed as an authoritative source of information. While there are no actual problems of illness to be solved, his didactic suggestions for maintaining the infant's health are accepted without question. To help ensure compliance, he uses demonstration, repetition, and support as ways

of influencing the mother's understanding and adaptation of new behaviors.

Pediatrics II

The last case study involves a young, white female resident who is seeing, for the first time, a middle-class, teenage brother and sister who have come to the clinic for required school physicals. She first checks the fourteen year old sister, who has no medical problems. During the course of the examination, the girl confides that her brother, who is two years her senior, wants to continue playing sports even though he has a knee problem. This inadvertent piece of information sets the scene for the half-hour interview with the boy.

When he enters the room, the physician broaches the subject of his knees. He confirms that he, indeed, has a problem, which was most recently examined during a physical one year ago. It has prohibited his participation on the varsity hockey team, to which he would like to return. The doctor probes for more information, first with an open-ended question ("tell me what has happened"), then with specifics concerning pain and swelling. The resident is informal, friendly, but visibly nervous herself in regard to the presence of the video camera. In an effort to extract information from her young patient, she sometimes makes assumptive statements in lieu of evoking his own feelings. For instance, she states that he wants to go back to hockey instead of asking how he feels about playing sports. She then advises him to do what he can until the pain becomes too great.

Once the major issue is first discussed, she goes through his chart, checking past problems and hospitalizations. The doctor summarizes by proclaiming that his only problem is his knees. Once again, she preempts

the possibility of unknown information from the boy with a negatively phrased, closed ended question, "There's nothing else you're anxious or upset about?"

Announcing that they will go on to the physical, she leaves the room while he undresses. Upon re-entering, she assures him that the exam will not hurt and that she will explain procedures before doing them. She performs a review of organ systems along with the physical, giving brief intermittent feedback in the form of "okay" or "sounds fine." Thy physician is very specific in checking possible symptoms associated with sports activity. The patient volunteers that he is aware of shortness of breath associated with running. During some of the more sensitive moments of the examination, the resident resorts to some "diversionary" tactics in order to ease any tension the boy might be feeling. For example, when probing about bowel movement patterns, she jokes, then asks about school and his favorite subjects. Then, while examining the genitals, she talks about his feelings concerning sports.

Once the physical is completed, the two discuss what should be done. For the most part, the physician explains her opinions and the patient listens without much comment. She questions the value of yet another x-ray, assures him that the knee pain is a common condition among people his age, and reiterates that if he resumes playing, he will have to quit if the knees start to hurt. At this point, a more experienced, attending physician is brought in to consult about the boy's knees. To some extent, she reiterates what the resident has said, but relates to the patient in a different way. She suggests the option of exercise by swimming, and the young man responds, indicating that it is really hockey in which he is

interested. Other considerations are discussed, including the possibility of referral to an orthopedist, and updating the x-ray examinations. In terms of problem-solving, an important aspect is that the patient becomes actively involved in the negotiations and is addressed as being responsible for his choices. The final outcome is that he will consult with his parents, probably undergo another x-ray, and try to play hockey again, but will stop if the knee pains return.

When the attendent leaves, the resident talks to the boy about correct breathing methods while running, thus responding to a problem brought up earlier. She also checks with him to see how he feels about getting an x-ray in order to make sure this suggestion has not been imposed upon him.

The physicians in this interview have chosen to limit subject matter to physiological aspects, though one has the feeling that some probing of psychological topics -- how the boy feels about himself since he has had to stop playing hockey, how non-participation in sports has affected peer relationships, fears the patient might harbor concerning future implications of this health problem -- may have expanded the data base and, perhaps, have affected decision-making. The resident establishes rapport with her patient through a friendly, concerned, and informal manner. She is aware of the unspoken constraint that may exist because of the difference in sexes, especially during the physical exam, and tries to defuse tension by using discourse to detract from the nonverbal behaviors. However, she seems to be unaware of cutting off the patient's participation in terms of close-ended phrasing of questions and assumptive statements. There is no attempt on her part to include the boy in problem-solving. This tendency seems more pronounced when contrasted with the approach of the second

doctor, who elicits opinions and feelings, and assigns the patient a self management role. Given the combination of authoritative advice and participation in decision-making, the boy's response is such that it seems probable he will follow through with the agreed upon plan. It is not clear how he will react if his attempt to play hockey should result in the continued aggravation of the knee.

Discussion

Rhetorical analysis in this study takes on a slightly altered direction than in more traditional contexts. In part, the analyses reveal efforts of the physicians to induce cooperation from the patient, especially in reference to issues of compliance, through direct persuasive appeals; these attempts can be discussed in much the same way as persuasive messages in public communication situations. However, the more predominant rhetorical aspect of the medical interview is of a subtler, transactive nature. Participants attempt to exert influence by symbolic means through negotiating the form and content of the interview. How well physicians are able to control and direct talk with their patients has a large impact on how medical problems are defined, and resolved or managed. This observation is especially true in ambulatory, primary care settings where the office visit constitutes the physician's only opportunity to affect the patient (as compared with hospitalized patients who have more frequent contact with physicians and whose environments, medications, sleeping and eating patterns, etc. can be more firmly regulated).

Within this admittedly limited sample, no qualitative differences along disciplinary lines were observed (contrary to the expectations of

the researcher). A notable difference, such as the amount of emphasis given to psychosocial matters in Family Practice I contrasted with the absence of such attention in Pediatrics II, was not borne out in the other case studies and, thus, must be attributed to individual physician style and judgment, for the time being. Although goal orientation for the physicians seems demonstrably intentional, rhetorical sensitivity to the unique aspects of each patient and situation is practiced at a less conscious level. While the case studies reveal a wide repertory of specific, adaptive behaviors exercised, there are general classifications of rhetorical strategy common to this communicative situation that can be summarized briefly.

Questioning

A very small proportion of time in these interviews is used for patients to ask questions. Partially by necessity of the task, and partially because of social expectations, the physician has primary responsibility for posing questions and these become important ways of shaping the discourse. Open-ended questions, as illustrated in these cases, work to invoke the participation of the patient. Closed-ended questions, when used appropriately, aid in giving direction to the flow of talk and eliciting particular kinds of detail. Occasionally, these are used dysfunctionally, cutting off possible informative contributions from patients and/or prematurely implying unsubstantiated conclusions.

Topic Initiation and Changes

This function, once again, is a primary responsibility of the physician. Introduction of "major" topics, such as presenting problem, past medical

history, family situation, review of systems, physical diagnosis, and treatment plan, is the primary method available to the doctor for imposing an organizational framework on the discussion. To a large degree, the timing of topic changes also sets the pace for the interview, discreetly encouraging an elaborated response from the patient (if the topic is not changed) or pushing on the conversation. Transitions are also an effective way of changing the focus of talk, for example, switching the patient's attention from physiological to psychosocial issues, from past events to the present, or from subjective perceptions to more objective forms of information. The issue of what is to be talked about is a major source of difficulty in terms of the physician's control of the interview.

Deductive and Enthymemic "Arguments"

As in any discursive situation in which the communicator accumulates data in order to formulate conclusions and reach decisions, the physician can be regarded as a maker of arguments. There are at least two examples of more inductive approaches, one in which the patient was guided toward reaching her own conclusion and another in which the physician handled an analagous situation in the same manner in which he had instructed the patient. By far the more frequent are arguments that are deductively reasoned and directly addressed. The doctors tend to explain, prescribe, demonstrate, remind, and repeat. While this sort of reasoning may be less engaging than the former, patients react as if they expect to be told what to do.

Relationship Building

A great deal of interpersonal influence during medical interviews is entwined with the type of relationship that evolves between doctor and

patient. In these case studies, the physicians did appear to be more conscious of the relationship dimension as a source of persuasion than of other rhetorical strategies. Cultivation of rapport and trust, demonstration of support and concern, and, in one case, even careful distancing were approaches toward gaining patient cooperation.

Role-Taking

By the acknowledgment of both participants in the medical interview, the physician is the expert. Such pre-ordained ethos seems to be at once a major strength and weakness in this rhetorical situation. There is an implicit trust operating that the doctor will know the appropriate questions to ask, be able to judge how much talk is needed, and arrive at correctly derived conclusions. This assumption helps the physician to order and regulate the interview. It also gives the doctor an edge in overall persuasiveness, as in the case of Internal Medicine I, in which the physician pronounced the patient to be doing well despite her numerous list of complaints.

The irony rests with establishing a therapeutic plan with which the patient is supposed to comply. In all cases, therapy depends only to a slight degree on medication and laboratory procedures. Every patient seen has a chronic problem or situation -- be it obesity, family dynamics, toilet training -- that requires adaptation in life style. In other words, the desired end is self management. Yet, in only two cases is it suggested that patients assume an active role in problem solving. Not only physicians, but patients themselves, decline to recognize that their expert knowledge of themselves qualifies them to take part in the decisions that concern their health.

The authoritative image of the medical doctor is a powerful one; it facilitates the crucial function of regulating the communication with patients. However, the medical interview situation holds a special potential for influence in that both physicians and patients can be active participants in the discourse. Full realization of the interview as a rhetorical form will occur when patients are enjoined, not only in the task of eliciting information, but also in helping to reason through and decide the course of action that they are both willing and able to carry out.[5]

Footnotes

[1] Arthur Levin, Talk Back to Your Doctor: How to Demand (& Recognize) High Quality Health Care (Garden City, N.Y.: Doubleday & Co., Inc., 1975).

[2] Gary Kahn, Barry Cohen, and Hilliard Jason, "The Teaching of Interpersonal Skills in U.S. Medical Schools," Journal of Medical Education 54 (January, 1979(, 29-35.

[3] Daryl Matthews and Ralph Hingson, "Improving Patient Compliance: A Guide for Physicians," Medical Clinics of North America 61 (July, 1977), 879-889.

[4] Robert L. Scott, "A Synoptic View of Systems of Western Rhetoric," Quarterly Journal of Speech 61 (1975), 440.

[5] Added support for this position from a health educator's viewpoint can be found in: Barry Blackwell, "Counselling and Compliance," Patient Counselling and Health Education 1 (Fall, 1978), 45-49.